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ABSTRACT

This paper discusses N. B. Ralph's (1980) four stages of development for the novice therapist, focusing on the fourth stage (therapists become aware of their own feelings and reactions to the therapeutic process) through the author's experience in therapy. The therapist as client is discussed according to Karen Horney's classification of neurotic personality styles, and as a way for the therapist to focus on dependency, detachment, and countertransference. Encountering patients with problems similar to unresolved problems in the therapist, and the ability to relinquish control of patients during therapy are presented as outcomes of growth in personal therapy. (LLL)

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Therapist Autonomy As Countertransference

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N.B. Ralph (1980) proposed a developmental perspective to changes that occur within the novice therapist. He delineated four milestones or stages that most students experience while in training. These stages represent a change in perspective from more concrete conceptualizations about patients and therapy to more complex, abstract ideas and formulations.

Ralph (1980) suggested that during the first stage of development as a therapist, the student learns to offer less direct advice and to assist the patient in broadening her understanding of life conflicts and in discovering alternative choices to various situations.

The second stage involves the development of the ability to look beyond the verbalizations and understand the non-verbal communication of the patient. During this phase, the therapist learns to conceptualize the patient less concretely, taking into consideration multiple factors that affect the patient's current adjustment. Also during the second phase, the therapist discovers his own orientation to therapy.

The third milestone is an interpersonal process that involves both the therapist and the patient. At this point, the student begins to focus on the process of therapy rather than almost exclusively on the content.

The fourth stage involves a therapist-centered perspective whereby the therapist becomes aware of his own feelings and reactions in the therapeutic process.

One way that Ralph (1980) suggests that students achieve the fourth milestone is to become involved in their own experiences in therapy. Personally, I found that my own experience in therapy was beneficial to my development in all four of these hypothesized stages. Initially, my own experience in therapy gave me an idea of what it feels like to be a patient. This included the feelings of reluctance to confide in another person with whom I was just beginning to become acquainted as well as points along the road in therapy where I realized how resistant I was to divulge certain aspects of myself even though I had since formed a trusting relationship with my therapist. I also found that my therapist and my journey through therapy became a model for my own techniques as a therapist and the process of change in therapy. I found that my experience in therapy became a valuable learning tool through which I gained empathy for my patients' experiences and made taking the role of the other easier and more meaningful.

As I turned my attention to my ability to trust my reactions and feelings as a source of information rather than anxiety in my work with my patients, I confronted my personal counter-transference issues and began to work toward a better understanding of them and their usefulness in therapy.

As I began conducting psychotherapy, I initially noticed

which of the patients with whom I was working I "liked" and which I "disliked." It was not difficult to determine that the patients I "liked" were the ones who were dependent upon our relationship, who turned to me for advice and who wanted me to control the course of therapy. I felt comfortable with that type of patient. Conversely, the patients who did not behave as I thought they "should" during the therapy hour soon began to irritate me. Thus, the clue to the first kind of countertransference I exhibited was my desire to control the therapy hour. With this clue I began to investigate my need to control and the anxiety I experienced when control was not possible. In my own therapy I was able to explore my unresolved autonomy issues and the effect they had upon my competence as a therapist.

On the one hand, I found myself exhibiting positive countertransference with those patients who allowed me to control the therapy hour. Allowing the therapy session to run overtime, being ingratiating with those patients, and keeping a patient in treatment too long are three examples of the positive countertransference that I experienced with those patients.

On the other hand, with a patient who did not allow me to control the hour and who did not act as I thought he should have, I found myself becoming overly casual about

missed appointments and looking for reasons to terminate prematurely. These mistakes were not the most dangerous, however. As I worked through these initial manifestations of unresolved autonomy issues as countertransference, I began to become aware of more insidious forms of this threat to effective therapy.

In an effort to describe myself to my therapist, I used Karen Horney's classification of neurotic personality styles. In her view, the neurotic person experiences a basic conflict composed of the contradictory attitudes he concurrently holds toward other people. In each of the contradictory attitudes one of the elements of basic anxiety, helplessness, hostility, or isolation is overemphasized while the others are repressed. From this concept, Horney described three styles of being in the world: the person who moves toward people, the person who moves against people or the person who moves away from people.

An individual in whom the aggressive and compliant attitudes and values are equally present is the detached person, or the person who moves away from others. The most obvious characteristic of the detached personality is an estrangement from people in general. In addition, an estrangement from the self is evident such that the individual experiences a type of emotional numbness. The person's crucial need, to put emotional distance between himself and others, results in

both a conscious and unconscious determination not to become emotionally involved with others. While superficially these individuals appear to get along with people, they experience intense anxiety when the world intrudes upon their private experience. The detached person's motto is never to become attached to another individual such that the individual becomes indispensable. This creates a need to be self-sufficient that drives the detached person to develop resources upon which to rely. Disruptions of self-sufficiency often result in feelings of helplessness or aggression. However, detachment is usually regained and maintained as the attitude of preference.

Identifying my own tendency toward detachment helped me to further understand how my countertransference issues affected my competence as a therapist. I realized that the unresolved autonomy issues, in addition to creating a need to control myself and others, most probably colored my experience in attempts to establish meaningful relationships. In order to avoid the underlying affective threat of a loss of self, I used the cognitive defense of intellectualization to distance myself emotionally from myself and others. I also realized that, to some extent, my drive toward success in professional endeavors was a way of attaining the self-sufficiency I felt I needed in order to be less dependent

and more detached from others.

These personal characteristics were played out in different ways with different patients. With one patient, a thirty-four year old, recently divorced woman, I found myself guiding her toward self-sufficiency and away from dependent relationships with men. Rather than attempting to conceptualize a number of alternatives with the patient toward the resolution of her dilemmas, I would become too narrowly focused and lose creativity during the sessions. Also, at times when the patient would bring up what was for me an anxiety-arousing topic, I discovered that I tried to intervene so as to discourage her from continuing with the topic. Additionally, I was unable to recognize some of the ways in which she was using intellectualization for emotional distancing and ways in which she attempted to control the relationships in her life.

In another case I was conducting marital therapy with a woman who was struggling to maintain her dependence upon her very controlling husband. Their problems involved the wife's resentment toward her husband's attempts to get her to develop self-sufficiency. On the one hand, the husband was trying to encourage the development of the wife's autonomy. The ways in which he was attempting to foster that growth, however, were controlling and demanding. I found myself having difficulty in relating to the husband, tending to see his attempts to control as the main source of the problems in the

relationship. At the same time, I tended to ignore the wife's dependency issues, assuming that she would be able to grow as long as the husband would learn to relinquish some of his attempts to control. At times I hoped that he would drop out of therapy. As Weiner (1975) pointed out, "the likelihood of premature termination increases when therapists encounter patients with problems similar to unresolved problems in themselves." I was seeing how that was occurring in my own therapy cases.

There were times when my autonomy issues were involved in countertransference in a more beneficial way. As the totalistic view of countertransference suggests, the realization of unresolved autonomy issues gave me insight into some of my patients' underlying conflicts and the various ways in which they were manifested in behavior.

Also during my personal therapy I began to see how early environmental influences affected my personality development and the development of the conflicts that are behind the countertransference. However, learning the ways in which conflicts developed is not sufficient for understanding the ways in which they are played out in current life. An understanding of the present functions of the conflict and the defense mechanisms employed to deal with the conflict gave me insight into my behavior, my patients' behavior and how my effectiveness as a therapist was being diminished.

As I progressed in my own therapy, I assumed more responsibility for my actions and feelings. I also developed more fully an independence that allowed me to be less fearful of life situations, and thus, more spontaneous. This growth translated into the ability to relinquish control during therapy sessions with my patients. As I was better able to relax, I found that my creativity during therapy was enhanced such that I was less restrictive in my conceptualizations of patients and more adept at facilitating their growth. Hopefully, with additional growth, I will become more aware of countertransference issues as they are beneficial to therapy or as hinderances, and will become skillful in using them or discarding them in appropriate ways. It is my opinion that continuous growth across the life-span brings with it, not only oppurtunities to find increased enjoyment in existence, but also the responsibility to enhance one's abilities wherever possible.

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